



**Insurance and Real Estate Committee
PUBLIC HEARING
Tuesday, March 15, 2022**

**Connecticut Association of Health Plans
Testimony Regarding**

**S.B. No. 358 AAC REQUIRED HEALTH INSURANCE COVERAGE FOR BREAST HEALTH
BENEFITS.**

The Connecticut Association of Health Plans urges caution as the legislature seeks to further expand the coverage mandates related to breast imaging. Connecticut statutes already cover a broad range of radiologic treatments and services. Codifying specific treatment regimens in statute raises concerns as appropriate protocols change with emerging science and evidence based practice guidelines change accordingly.

Respectfully, we would also urge the committee to consider that the Affordable Care Act (ACA) requires qualified health plans (QHPs) offered on the Exchange to include a federally defined essential health benefits package (EHB). While states are allowed to mandate benefits in excess of the EHB, federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the Exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan. Consideration should be given as to whether S.B. 358 constitutes a new mandate under these provisions.

It's also worth noting that none of the mandates under consideration by the Committee would apply to those individuals, including state employees, that are covered by self-insured plans. The burden of any increased cost would fall only on the fully-insured market that primarily encompasses small employers and individuals that are the most price sensitive. More and more companies and government entities that can afford to take the risk are moving to self-funded plans which allow them to set their benefit structures more within the scope of their individual group's needs and budget. The ratio of self-insured to fully-insured groups in CT is now nearing 70% to 30%. As the ACA recognized, the system cannot continue to absorb the additional costs of new mandates.

The ACA established a strict time table for benefit design, rate development, submission, and approval that is compromised by the legislative calendar and passage of any new mandates. That process is currently underway for calendar year 2023. The Exchange is developing the standard benefit designs and carriers are developing their non-standard plan designs. If any new mandated provisions are adopted after the benefit designs have been finalized and rates have been filed, the Exchange and the carriers will have to reopen the entire process allowing for adjustments to the AV calculator, re-submit all templates, and refile all rates or absorb the associated cost. The sheer depth and breadth of new mandates under current consideration add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market.

Thank you for your consideration.